DUAL Medical Expenses

Claim Form: Expatriate and Temporary Resident Medical Expenses Insurance

Please Ensure

The issue of this form is not an admission of liability

- You have fully completed every question on this form including Appendix A. Failure to do so will result in delay in handling your claim.
- If any question is not applicable please state 'N/A'
- You have enclosed all requested information/documentation.
- You have signed this claim form.
- All medical receipts are submitted with this form
- All receipts are itemised and written in English or with an English translation. A credit card slip showing payment is not sufficient.

Section 1 - Claimant Details

Insured Name: Policy number

Name of Employee /Claimant:

Date of Birth: Nationality:

Address:

Business Phone: Mobile Phone:

Email:

Section 2 - Medical Information

Patient's Name: Date of Birth:

Please give full details of injury/onset of illness:

Date of Injury or manifestation of Illness:

When did the patient first receive medical attention for this condition?

Is there any entitlement to compensation under workers compensation, government law or other insurance? Yes ☐ No ☐

If YES, please give details:

Has the patient ever suffered with this or any similar condition before the present episode? Yes ☐ No ☐

If YES, please give details including dates of treatment and consultation:

Section 3 - Payee Bank Details

When the claim has been approved the payment will be credited direct to your Bank Account.

Please complete the following:

Currency for reimbursement:

Bank Name:

Bank Address:

Swift Code:

Account Name(s):

BSB Number:

Account Number:

Declaration

Claim Lodgement Details

Please forward claim details using one of the following lodgement processes

(Please keep a copy of all documents sent to CSN)

Postal Address:

Corporate Services Network

GPO Box 4276

Sydney, NSW 2001

Email Address:

claims@csnet.com.au

Fax No:

+61 2 8256 1775

Phone Number:

Once the claim form has been completed, sent, and received by CSN, claim inquiries can be made to CSN on:

+61 2 8256 1770

Policy and coverage queries should first be directed to your Insurance Broker.

Privacy Collection Statement:

We are committed to protecting your privacy and complying with the *Privacy Act 1988* (Cth) ('Privacy Act').

We use your information to assess the risk of providing you with insurance, provide quotations, issue policies and assess and manage claims, on behalf of the insurers we represent. If you do not provide us with full information, we may not be able to provide insurance or assess and manage a claim. If you provide us with information about someone else, you must obtain their consent to do so.

We may provide your personal information to the insurer we represent, insurance regulators and other insurance bodies as required by law. We may also provide your information to your broker and any third party claims service providers (such as claims management companies, parties repairing or replacing the subject matter, loss adjusters and appointed law firms (and the like)). If a recipient is not regulated by laws which protect your information in a way that is similar to the Privacy Act, we will take reasonable steps to ensure that they protect your information in the same way we do or seek your consent before disclosing your information to them. We do not trade, rent or sell your information.

Our Privacy Policy contains more information about how to access and correct the information we hold about you and how to make a privacy related complaint, including how we will deal with it. By providing us with your personal information, you consent to its collection and use as outlined above and in our Privacy Policy. Ask us for a copy of our Privacy Policy via email at privacy@dualaustralia.com.au or access it via our website using the following link.

Declaration and Authorisation Complete for all Claims

- I declare that the information on this form and any documents attached to it, is correct and complete and that I have not withheld any information that could effect this claim.
- I authorise any hospital, physician or other person who has attended me to furnish the claims manager Corporate Services Network (CSN) or its representatives any and all information with respect to any sickness or injury, medical history, consultation, prescriptions, or treatment, copies of all hospital or medical reports. I agree that a Photocopy of this authorisation shall be considered as effective as the original.

Full Name:

Position:

Signature:

Date: